EXHIBIT K

GfK Healthcare

EVRI Preliminary Positioning

- Physician Qualitative NSCLC DG (50 minutes) -

OBJECTIVES :

- **Uncover emotional unmet needs**
- **Uncover functional unmet needs**
- **Gather response to Product Profile to understand the potential to fill the unmet emotional/functional needs**

INTRODUCTION

- Introduction to GfK Healthcare.
- Discussion will be purely for marketing research purposes only and non-promotional in nature. Respondent anonymity will be maintained. Conversation will be tape-recorded for note-taking purposes.
- [In CL IDIs] Colleagues observing behind mirror, via videoconferencing, etc.
- Purpose of discussion: To understand current practices and opinions regarding treatment of NSCLC as well as to evaluate a product profile of a new oncology agent in development.

I. Warm-Up (5 minutes)

1) Please tell me a little about your current practice:

2) Please tell me the type of patients that you serve.
   a) What proportion of your patients is under your care for treatment of NSCLC?
   b) Please describe your NSCLC patient population. **PROBE:** by age groups, gender, socioeconomic background, insurance coverage type.
   c) In terms of the range of tumor types that you treat, how does NSCLC compare? Is it more or less challenging? Why?
   d) How about the NSCLC patients themselves, are they more or less challenging than other kinds of cancer patients that you treat?
   e) How do you view your relationship to your cancer patients in general? (If necessary, probe on how important it is to get to know the patient, the family, etc. vs. how important it is to maintain a professional distance). Is your approach similar with NSCLC patients?

II. Exploration of Emotional Unmet Needs/Benefits (15 minutes)

3) I would like understand more about your experience interacting with your newly diagnosed, or newly progressed, stage III and IV NSCLC patients – now that they are under your care, requiring treatment of the lung cancer, please walk me through the thoughts you may have as you interact with the patient. Here I have a diagram – I would like you to fill out each of the bubbles to describe your interaction with newly diagnosed/progressed stage III/IV NSCLC patients. **HAND THE BUBBLE DIAGRAM TO THE RESPONDENT**
   [FOR EACH BUBBLE, ASK]
   a) Please explain your response. Why did you put this response down in this bubble? What triggers these thoughts/feelings? **[MODERATOR: THIS IS A PROJECTIVE TECHNIQUE TO UNCOVER EMOTIONAL NEEDS AND BENEFITS PHYSICIANS ARE EXPERIENCING TODAY – PROBE AS MUCH AS POSSIBLE TO IDENTIFY EMOTIONS (examples include: "frustration about lack of effective therapies", "sense of discouragement because of short survival", "fearful of severe SE associated with doublet therapy", etc. PROBE REGARDING DISCONNECTS (e.g. Uncover why they might hesitate to say what they are thinking...)**

4) Next, let's fast-forward to 5 years from now. I would like you to assume that there are more and better therapy options available in 5 years – please repeat the same exercise again. I would like to understand how you envision you will interact with your newly diagnosed, or newly progressed, stage III and IV NSCLC patients in 5 years with better therapies available. **HAND A NEW BUBBLE DIAGRAM TO THE RESPONDENT**
[FOR EACH BUBBLE, ASK]
   a) Please explain your response. Why did you put this response down in this bubble? What triggers these thoughts/feelings?
      i) How did your response change from the last response (today vs. 5 years from now) – and what are the factors that influence the change in your response?
         - How would you describe the "better therapy options"? Why? What would you anticipate these better options influence your interactions with NSCLC patients?
         - With better treatments, would that impact on your emotions? How so? Ultimately, how would you feel if there were better treatments available for your patients?
         - What new treatments can you imagine you might have in the future?

III. Exploration of Functional Unmet Needs/Benefits (40 minutes)

5) Next, I would like to talk to you about how you currently manage your NSCLC patients. Approximately what proportion of your patients is currently receiving 1st line monotherapy vs. combination therapy?

6) Please tell me what factors influence your selection of treatment for your NSCLC patients.
   a) When do you use monotherapy vs. combination?

7) Which agent(s) do you frequently consider for 1st line monotherapy?
[FOR EACH MENTIONED]
   a) In what circumstances do you select this agent?
      i) When selecting this agent, what is your primary treatment objective?
   b) What are the strengths/weaknesses of this agent?

8) Which combination therapies do you frequently consider for 1st line?
[FOR EACH MENTIONED]
   a) In what circumstances do you select this combination therapy?
      i) When selecting this combination therapy, what is your primary treatment objective?
   b) What are the strengths/weaknesses of this combination therapy?

9) Please tell me what factors influence your selection of 1st line treatment for your NSCLC patients?
   a) Tell me what disease characteristics are influential. Why these? [MODERATOR: PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Stage of disease
      ii) Histology
      iii) Biomarker testing (EGFR mutation, EGFR Fishing testing for gene copy number)
   b) How about patient characteristics? Which ones – and why these? [MODERATOR: EXCLUDE INSURANCE COVERAGE; PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Age
      ii) Physical condition/ECOG score
      iii) Willingness to be treated
      iv) Social and economic, education, etc.

10) What are the top unmet needs in the treatment of 1st line NSCLC? **PROBE:** by TNM staging, line(s) of therapy, tumor histology

11) What are the most important factors when you consider when using a new product for 1st line treatment of NSCLC? [MODERATOR: FIRST COLLECT UNAIDED RESPONSE THEN PROBE ON FOLLOWING]
   a) Better efficacy, i.e. improvement in OS or PFS?
      i) How many months of OS or PFS are the good enough to consider?
   b) Fewer side effects
      i) Improved quality of life?
   c) Dosing
   d) Updated treatment guideline
   e) Recommendations
      i) By global, regional and/or local organizations
      ii) Key Opinion Leaders (KOLs) and/or peers?
      iii) Which organization do you consider "the authority" in making recommendations for treatment of NSCLC in your region/country/the world?
   f) What would it take for a new therapy option to become a new treatment of choice? [MODERATOR: IF NOT MENTIONED/SPECIFIED, DIRECT THE CONVERSATION TO 1ST LINE MONOTHERAPY]

"Next, I would like to show you a product profile for a new NSCLC product."

HAND THE 1st LINE NSCLC PRODUCT PROFILE

12) Based on the information presented, what are your initial reactions to Product E?
   a) Which aspects in the product description are most important and compelling to you? Why?
      i) What do you like about this product?
      ii) What are the benefits Produce E offering?
      iii) Is there anything you dislike?
   b) Based on this profile, please tell me your opinions about:
      i) Efficacy
      ii) Safety and Tolerability
      iii) Dosing / Convenience
      iv) MoA
      v) Other considerations
   c) What aspect of this product makes it unique?

13) What are your opinions about the comparator used in this profile?

14) For what types of patients would you consider using Product E?
   a) Why these patients?
   b) Which treatments are currently used for these patients?

15) For what types of patients would you think Product E would be *un*suitable? Why?
16) What could you imagine this product would replace? Why?
17) Could Product E become your 1st line monotherapy agent of choice? Why or why not?
   a) **[IF NOT]** What data would you need to see in order for this to become your 1st line monotherapy agent of choice?

SECOND LINE TREATMENT PRACTICES AND UNMET NEEDS

18) When considering 2nd line treatments, what proportion of your patients are on monotheray vs. combination therapy? Please tell me what factors influence your selection of treatment for your NSCLC patients.
   a) When do you use monotherapy vs. combination?

19) Which agent(s) do you frequently consider for 2nd line monotherapy?

[FOR EACH MENTIONED]
a) In what circumstances do you select this agent?
   i) When selecting this agent, what is your primary treatment objective?
b) What are the strengths/weaknesses of this agent?

20) Which combination therapies do you frequently consider for 2nd line?
[FOR EACH MENTIONED]
a) In what circumstances do you select this combination therapy?
   i) When selecting this combination therapy, what is your primary treatment objective?
b) What are the strengths/weaknesses of this combination therapy?

21) Please tell me what factors influence your selection of 2nd line treatment for your NSCLC patients?
a) Tell me what disease characteristics are influential. Why these? [MODERATOR: PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
   i) Stage of disease
   ii) Histology
   iii) Biomarker testing (EGFR mutation, EGFR Fishing testing for gene copy number)
b) How about patient characteristics? Which ones – and why these? [MODERATOR: EXCLUDE INSURANCE COVERAGE; PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
   i) Age
   ii) Physical condition/ECOG score
   iii) Willingness to be treated
   iv) Social and economic, education, etc.

22) What are the top unmet needs in the 2nd line treatment of NSCLC? **PROBE:** by TNM staging, line(s) of therapy, tumor histology

23) What are the most important factors when you consider when using a new product for 2nd line treatment of NSCLC? [MODERATOR: FIRST COLLECT UNAIDED RESPONSE THEN PROBE ON FOLLOWING]
a) Better efficacy, i.e. improvement in OS or PFS?
   i) How many months of OS or PFS are the good enough to consider?
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c) Dosing
d) Updated treatment guideline
e) Recommendations
   i) By global, regional and/or local organizations
   ii) Key Opinion Leaders (KOLs) and/or peers?
   iii) Which organization do you consider "the authority" in making recommendations for treatment of NSCLC in your region/country/the world?
f) What would it take for a new therapy option to become a new treatment of choice? [MODERATOR: IF NOT MENTIONED/SPECIFIED, DIRECT THE CONVERSATION TO 1st LINE MONOTHERAPY] What would it take for a product to become the new monotherapy agent of choice (i.e. replace Tarceva)?

"Next, I would like to show you a product profile for a new NSCLC product."

HAND THE 2nd LINE NSCLC PRODUCT PROFILE

24) Based on the information presented, what are your initial reactions to Product E used 2nd line?
a) Which aspects in the product description are most important and compelling to you? Why?
   i) What do you like about this product?
   ii) What are the benefits Produce E offering?

iii) Is there anything you dislike?

b) Based on this profile, please tell me your opinions about:
   i) Efficacy
   ii) Safety and Tolerability
   iii) Dosing / Convenience
   iv) MoA
   v) Other considerations

c) What aspect of this product makes it unique?

25) What are your opinions about the comparator used in this profile?

26) For what types of patients would you consider using Product E 2nd line?
   a) Why these patients?
   b) Which treatments are currently used for these patients?

27) For what types of patients would you think Product E would be *un*suitable? Why?

28) What could you imagine this product would replace? Why?

29) Could Product E become your 2nd line monotherapy agent of choice? Why or why not?
   a) **[IF NOT]** What data would you need to see in order for this to become your 1st line monotherapy agent of choice?

30) What impact, if any, will this information for 2nd line treatment of NSCLC, have in your consideration to use Product E in use in 1st line??
   a) Why do you say that?

V. Closing Questions

MODERATOR: Check with back-room team to see if they have any additional questions.

GfK Healthcare

EVRI Preliminary Positioning

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- [In CL IDIs] Colleagues observing behind mirror, via videoconferencing, etc.
- Purpose of discussion: To understand current practices and opinions regarding treatment of breast cancer (BCa) as well as to evaluate a product profile of a new oncology agent in development.

I. Warm-Up (5 minutes)

1) Please tell me a little about your current practice:

2) Please tell me the type of patients that you serve.
   a) What proportion of your patients is under your care for treatment of BCa?
   b) Please describe your BCa patient population. **PROBE:** by age groups, gender, socioeconomic background, insurance coverage type.
   c) In terms of the range of tumor types that you treat, how does BCa compare? Is it more or less challenging? Why?
   d) How about the BCa patients themselves, are they more or less challenging than other kinds of cancer patients that you treat?
   e) How do you view your relationship to your cancer patients in general? (PROBE: How important is it get to know the patient, the family, etc. vs. how important it is to maintain a professional distance?). Is your approach similar with BCa patients?

II. Exploration of Emotional Unmet Needs/Benefits (15 minutes)

3) I would like to understand more about your experiences interacting with your newly diagnosed, or newly progressed, metastatic BCa patients – now that they are under your care, requiring treatment of the breast cancer, please walk me through the thoughts you may have as you interact with the patient. Here I have a diagram – I would like you to fill out each of the bubbles to describe your interaction with newly diagnosed/progressed stage III/IV BCA patients. **HAND THE BUBBLE DIAGRAM TO THE RESPONDENT**
   [FOR EACH BUBBLE, ASK]
   a) Please explain your response. Why did you put this response down in this bubble? What triggers these thoughts/feelings? **[MODERATOR: THIS IS A PROJECTIVE TECHNIQUE TO UNCOVER EMOTIONAL NEEDS AND BENEFITS PHYSICIANS ARE EXPERIENCING TODAY – PROBE AS MUCH AS POSSIBLE TO IDENTIFY EMOTIONS (examples include: "frustration about lack of effective therapies", "sense of discouragement because of short survival", "fearful of severe SE associated with doublet therapy", etc. PROBE REGARDING DISCONNECTS (e.g. Uncover why they might hesitate to say what they are thinking...)**

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6) Please tell me what factors influence your selection of treatment for your BCA patients.
   a) When do you use monotherapy vs. combination?

7) Which agent(s) do you frequently consider for 1st line monotherapy?
[FOR EACH MENTIONED]
   a) In what circumstances do you select this agent?
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   a) Tell me what disease characteristics are influential. Why these? [MODERATOR: PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Stage of disease
      ii) Histology
      iii) HER2
      iv) ER/PR
      v) Oncotype DX
   b) How about patient characteristics? Which ones – and why these? [MODERATOR: EXCLUDE INSURANCE COVERAGE; PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
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"Next, I would like to show you a product profile for a new BCa product."

HAND THE 2nd LINE BCa PRODUCT PROFILE

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V. Closing Questions

MODERATOR: Check with back-room team to see if they have any additional questions.

Product E – Features

Mechanisms of Action

- Potent and selective inhibition of EGFR
- Potent and selective inhibition of HER2
- Potent and selective Inhibition of VEGFR and VEGFR-mediated angiogenesis
- Blocks tumor resistance mechanism known as "cross-talk" which allows tumors to by-pass inhibition of one growth/survival signaling pathway by activation of another
- Overcomes resistance to other tyrosine kinases, such as erlotinib

Efficacy

- Active as monotherapy
- Active in biomarker selected patient subtypes
- Preclinical efficacy in HER2+ breast cancer models refractory to trastuzumab
- Active against wild type, activated mutant and deactivated mutant isoforms of EGFR
- Clinically validated anti-angiogenic activity
- 5 months improvement in PFS in 1st line MBC patients
- 1 month improvement in PFS and 3 months in OS versus erlotinib in 2nd line+ NSCLC
- 3 months improvement in PFS and 6 months in OS versus gefitinib in 1st line NSCLC with activating mutations of EGFR tyrosine kinase

1

Product E – Features

Safety and Tolerability

- Side effect profile predictable and manageable based on tyrosine kinase inhibition
- Safely combined with other targeted or chemotherapy agents
- Safely combined with antihormonal agents, such as aromatase inhibitors
- No known drug-drug interactions
- Less/reduced side effects compared to chemotherapy
- Most frequent toxicities
  - Diarrhea
  - Dermatitis Acneiform
  - Rash
  - Asthenia/Fatigue
  - Arthralgia
  - Hypertension
  - Rhinitis
  - Nausea
  - Dehydration

2

Product E – Features

Dosing / Convenience

- 200 mg tablet
- Once a day with single tablet

Other Considerations

- Possible cost effectiveness (substitutes for multiple IV administered drugs)
- Active in patients across histologies
- Consistent clinical profiles in major ethnic groups including White, Black, Latino, and Asian
- Consistent clinical profiles in men and women
- Consistent clinical profiles in smokers, light smokers, and never smokers

3

Product E - Background in Non-Small Cell Lung Cancer (NSCLC)

- Product E is a novel selective inhibitor of EGFR and VEGFR with anti-proliferative and anti-angiogenic activity.
- Product E is active against wild type, activated mutant and deactivated mutant isoforms of EGFR and suppresses VEGFR mediated tumor angiogensis
- Product E is administered orally once daily, one 200-mg tablet.
- Product E monotherapy was evaluated globally for two indications in NSCLC:
  1) For the treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen
  2) For the 1st line treatment of locally advanced or metastatic NSCLC with activating mutations of EGFR tyrosine kinase
- Activating mutation in the EGFR occur in 5 -10% of lung cancers in Europe and the US, and 30-50% in Asia. Studies have shown that these types of tumors are more sensitive to EGFR tyrosine kinase inhibitors, such as gefitinib or erlotinib than chemotherapy doublets.
- Use of EGFR inhibitors in second line NSCLC is generally confined to patients with EGFR+ disease, regardless of mutation status, however, deactivating mutations often lead to resistance to current EGFR inhibitors.

Resistance frequently occurs among breast cancer patients who are treated with antihormonal therapies, such as tamoxifen or aromatase inhibitors (AIs). In spite of ER+ and/or PgR+, some tumors progress within three months of antihormonal use. Other tumors develop resistance over a longer period of time, while the patient is exposed to antihormonal therapy. Another form of antihormonal resistance is seen when patients complete the standard 5 years of therapy and the tumor rapidly progresses.

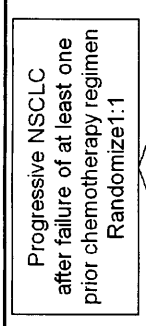
All of these tumors have multiple factors in common. These include the overexpression of HER2, increased expression of VEGF and the development of EGFR overexpression in the resistant tumors. All of these factors have been implicated in the development of antihormonal resistance by their individual activation of the phosphatidylinositol 3-kinase/Akt pathways and the activation of phosphoMAPK from the activation of the Ras pathway. These pathways not only block the activity of antihormonal therapies but have also been shown to cause tamoxifen stimulated tumor growth. These interactions between the antihormonal and oncogenic signaling pathways have been termed "crosstalk."

The inhibition of crosstalk has been studied using agents that inhibit only one or two of these pathways (e.g., TAnDEM using trastuzumab with anastrozole and EGF30008 using lapatinib with letrozole). These methods have shown improvement in the progression-free survival but bypass pathways, such as VEGF, eventually develop to lead to further antihormonal resistance.

EVRI has been developed as an orally administered tyrosine kinase inhibitor to inhibit the three most important crosstalk targets, EGFR, HER2 and VEGFR, simultaneously. This inhibition of multiple pathways using one agent will reverse resistance to antihormonal therapy while interfering with the tumor's ability of invasion, survival and development of vascularization.

Product E- Profile in 2nd line NSCLC after Prior Chemotherapy

- **Product E is approved as monotherapy for the treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen based on a Phase III study vs. erlotinib**



Efficacy

Overall Survival

Product E 9.7 months
Erlotinib 6.7months
(45% increase in median overall survival)

Progression Free Survival

Product E 3.3 months
Erlotinib 2.2 months
(50% increase in median progression free survival)

Safety

Product E

	Any Grade	G3	G4
Diarrhea	90%	8%	
Dermatitis Acneiform	37%	0%	
Rash	31%	0%	
Asthenia	29%	1%	
Rhinitis	16%	0%	
Acute Renal Insufficiency	10%	3%	0%
Nausea	19%	0%	
Hypertension	3%	0%	3%

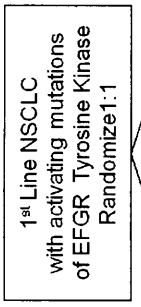
Erlotinib

	Any Grade	G3	G4
Rash	75%	8%	<1%
Diarrhea	54%	6%	<1%
Anorexia	52%	8%	1%
Fatigue	52%	14%	4%
Dyspnea	41%	17%	11%
Cough	33%	4%	0%
Nausea	33%	3%	0%
Infection	24%	4%	0%
Vomiting	23%	2%	<1%

5

Product E- Profile in 1st Line NSCLC with Activating Mutations of EGFR

- Product E is approved as monotherapy for the 1st line treatment of locally advanced or metastatic NSCLC with activating mutations of EGFR tyrosine kinase based on a Phase III study vs. gefitinib



Efficacy

Overall Survival

Product E 31 months
Gefitinib 25 months
(25% increase in median overall survival)

Progression Free Survival

Product E 12.4 months
Gefitinib 9.5 months
(30% increase in median progression free survival)

Safety

Product E

	Any Grade	G3	G4
Diarrhea	90%	8%	
Dermatitis Acneiform	37%	0%	
Rash	31%	0%	
Asthenia	29%	1%	
Rhinitis	16%	0%	
Acute Renal Insufficiency	10%	3%	0%
Nausea	19%	0%	
Hypertension	3%	0%	3%

Gefitinib

	Any Grade	G 3/4
Rash	65%	3%
Neurotoxicity	11%	<1%
Diarrhea	47%	4%
Alopecia	11%	0%
Anorexia	22%	2%
Nausea	17%	<1%
Vomiting	13%	<1%
Myalgia	8%	<1%
Dry skin	24%	0%

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Product E – Background in Breast Cancer

- Product E is a novel selective inhibitor of EGFR, HER2 and 4, and VEGFR1, 2, & 3 with anti-proliferative and anti-angiogenic activity.
- Product E restores hormone sensitivity to patients with ER+ MBC by efficiently blocking tumor resistance mechanism known as "cross-talk" which allows tumors to by-pass inhibition of the ER pathway.
- Product E is administered orally once daily, one 200-mg tablet in combination with the recommended daily dose of letrozole of 2.5 mg
- Product E in combination with letrozole was evaluated globally for the treatment of locally advanced or metastatic breast cancer in post-menopausal women who are either:
  1) HR+ and over-express HER2
  2) Or, those who are HER2– and have relapsed within 6 months after completing adjuvant hormone therapy.

Resistance frequently occurs among breast cancer patients who are treated with antihormonal therapies, such as tamoxifen or aromatase inhibitors (AIs). In spite of ER+ and/or PgR+, some tumors progress within three months of antihormonal use. Other tumors develop resistance over a longer period of time, while the patient is exposed to antihormonal therapy. Another form of antihormonal resistance is seen when patients complete the standard 5 years of therapy and the tumor rapidly progresses.

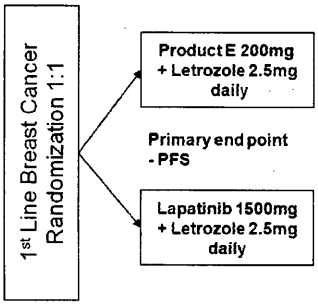
All of these tumors have multiple factors in common. These include the overexpression of HER2, increased expression of VEGF and the development of EGFR overexpression in the resistant tumors. All of these factors have been implicated in the development of antihormonal resistance by their individual activation of the phosphatidylinositol 3-kinase/Akt pathways and the activation of phosphoMAPK from the activation of the Ras pathway. These pathways not only block the activity of antihormonal therapies but have also been shown to cause tamoxifen stimulated tumor growth. These interactions between the antihormonal and oncogenic signaling pathways have been termed "crosstalk."

The inhibition of crosstalk has been studied using agents that inhibit only one or two of these pathways (e.g., TAnDEM using trastuzumab with anastrozole and EGF30008 using lapatinib with letrozole). These methods have shown improvement in the progression-free survival but bypass pathways, such as VEGF, eventually develop to lead to further antihormonal resistance.

EVRI has been developed as an orally administered tyrosine kinase inhibitor to inhibit the three most important crosstalk targets, EGFR, HER2 and VEGFR, simultaneously. This inhibition of multiple pathways using one agent will reverse resistance to antihormonal therapy while interfering with the tumor's ability of invasion, survival and development of vascularization.

Product E plus Letrozole Profile in 1st Line Breast Cancer

Product E in combination with letrozole was evaluated for an indicated use for the treatment of MBC in post-menopausal women who are either: HR+ and over-express HER2: Or, those who are HER2– and have relapsed within 6 months after completing adjuvant hormone therapy.



Efficacy

Progression Free Survival (primary endpoint)

Product E + letrozole	13.2 months
Lapatinib + letrozole	8.2 months

Overall Survival (secondary endpoint)

Product E + letrozole	33.0 months
Lapatinib + letrozole	28.5 months

DCR of 75% vs. 48%
Overall response rate of 49% vs. 28%

Safety

Product E + letrozole

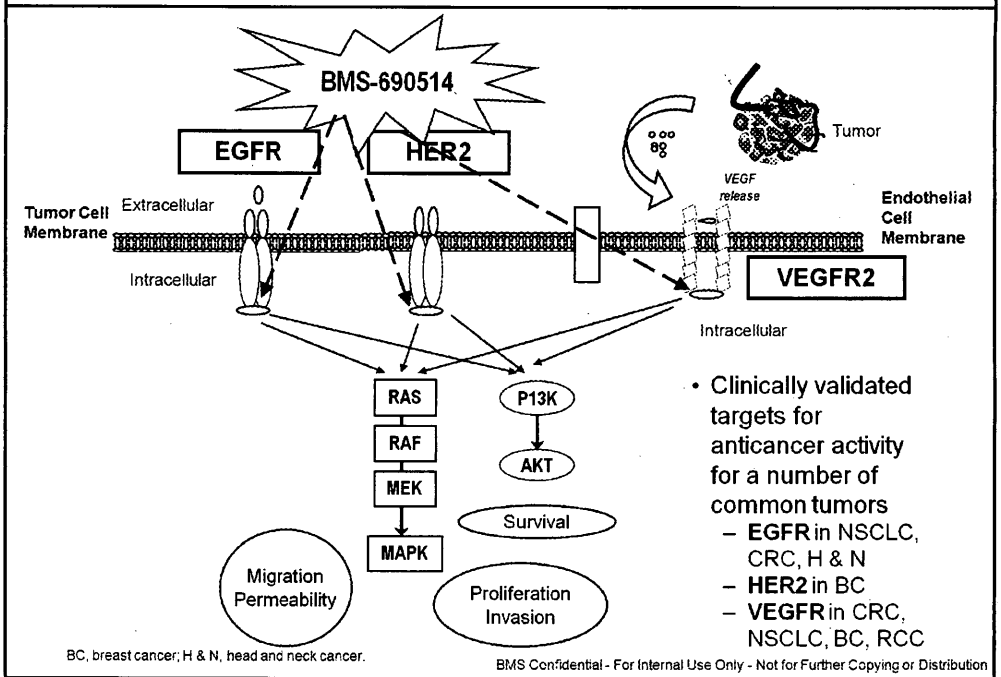
	Any Grade	G3	G4
Diarrhea	90%	8%	
Dermatitis Acneiform	37%	0%	
Rash	29%	0%	
Asthenia	29%	1%	
Arthralgia	20%	0%	
Nausea	19%	0%	
Hot flashes	14%	0%	
Acute Renal Insufficiency	10%	3%	0%
Hypertension	3%	0%	3%

Lapatinib + letrozole

	Any Grade	G3	G4
Diarrhea	45%	9%	<1%
Rash	45%	1%	
Nausea	30%	0%	
Fatigue	20%	<1%	
Arthralgia	20%	1%	
Vomiting	17%	0%	
Back pain	15%	0%	
Headache	14%	0%	
Asthenia	12%	1%	
Hot flashes	11%	0%	

- **Supplemental Information:**
  - Detailed MOA on Product E
  - Gefitinib – Background in Non-Small Cell Lung Cancer (NSCLC)
  - Lapatinib – Background in Breast Cancer
  - Product E – Functional Benefits
  - Product E – Reasons to Believe

Product E – Mechanism of Action



- Clinically validated targets for anticancer activity for a number of common tumors
  - **EGFR** in NSCLC, CRC, H & N
  - **HER2** in BC
  - **VEGFR** in CRC, NSCLC, BC, RCC

BC, breast cancer; H & N, head and neck cancer.

Gefitinib – Background in Non-Small Cell Lung Cancer (NSCLC)

- Gefitinib is a small molecule epidermal growth factor receptor (EGFR) inhibitor.
- Gefitinib is indicated in Europe for the treatment of patients with locally advanced or metastatic NSCLC with activating mutations of EGFR tyrosine kinase. Regulatory reviews are going in other countries.
- Gefitinib was assessed in the first-line IPASS study among 1217 Asian patients. These patients had advanced NSCLC of adenocarcinoma histology who were ex-light smokers or never smokers. The patients were randomized to receive gefitinib orally once daily or carboplatin/paclitaxel once every three weeks.
- Gefitinib is administered orally once daily, one 250-mg tablet

Study primary endpoint progression-free survival

EGFR mutation +	Gefitinib	Carbo/Pac	Hazard Ratio	*p*-Value
PFS	Median 9.5 m	Median 6.3 m	0.48	<0.0001
Overall Survival	Not reached	19.5 m	0.78	
Objective Response	71%	47%		0.0001

EGFR mutation-	Gefitinib	Carbo/Pac	Hazard Ratio	p-Value
PFS	Median 1.5 m	Median 5.5 m	2.85	<0.0001
Overall Survival	12.1 m	12.6 m	1.38	
Objective Response	1.1%	23.5%		0.001

Resistance frequently occurs among breast cancer patients who are treated with antihormonal therapies, such as tamoxifen or aromatase inhibitors (AIs). In spite of ER+ and/or PgR+, some tumors progress within three months of antihormonal use. Other tumors develop resistance over a longer period of time, while the patient is exposed to antihormonal therapy. Another form of antihormonal resistance is seen when patients complete the standard 5 years of therapy and the tumor rapidly progresses.

All of these tumors have multiple factors in common. These include the overexpression of HER2, increased expression of VEGF and the development of EGFR overexpression in the resistant tumors. All of these factors have been implicated in the development of antihormonal resistance by their individual activation of the phosphatidylinositol 3-kinase/Akt pathways and the activation of phosphoMAPK from the activation of the Ras pathway. These pathways not only block the activity of antihormonal therapies but have also been shown to cause tamoxifen stimulated tumor growth. These interactions between the antihormonal and oncogenic signaling pathways have been termed "crosstalk."

The inhibition of crosstalk has been studied using agents that inhibit only one or two of these pathways (e.g., TAnDEM using trastuzumab with anastrozole and EGF30008 using lapatinib with letrozole). These methods have shown improvement in the progression-free survival but bypass pathways, such as VEGF, eventually develop to lead to further antihormonal resistance.

EVRI has been developed as an orally administered tyrosine kinase inhibitor to inhibit the three most important crosstalk targets, EGFR, HER2 and VEGFR, simultaneously. This inhibition of multiple pathways using one agent will reverse resistance to antihormonal therapy while interfering with the tumor's ability of invasion, survival and development of vascularization.

Lapatinib – Background in Breast Cancer

- Lapatinib is an oral selective inhibitor of EGFR and HER2 and is approved for use in combination with capecitabine among patients who have advanced or metastatic breast cancer and over-express HER2 that progressed after an anthracycline, a taxane and trastuzumab.
- Lapatinib was studied by Johnston et al in the EGF30008 Trial comparing lapatinib + letrozole to placebo + letrozole.
  - Among the HER2+ population, there was an increase in the median PFS from 3.0 months to 8.2 months
  - An improvement was also noted among HER2- patients who relapsed within 6 months of completing adjuvant tamoxifen. The median PFS improved from 3.1 months to 8.3 months
- Lapatinib is administered orally once daily (six 250-mg tablets) in combination with the recommended dose of letrozole.

Resistance frequently occurs among breast cancer patients who are treated with antihormonal therapies, such as tamoxifen or aromatase inhibitors (AIs). In spite of ER+ and/or PgR+, some tumors progress within three months of antihormonal use. Other tumors develop resistance over a longer period of time, while the patient is exposed to antihormonal therapy. Another form of antihormonal resistance is seen when patients complete the standard 5 years of therapy and the tumor rapidly progresses.

All of these tumors have multiple factors in common. These include the overexpression of HER2, increased expression of VEGF and the development of EGFR overexpression in the resistant tumors. All of these factors have been implicated in the development of antihormonal resistance by their individual activation of the phosphatidylinositol 3-kinase/Akt pathways and the activation of phosphoMAPK from the activation of the Ras pathway. These pathways not only block the activity of antihormonal therapies but have also been shown to cause tamoxifen stimulated tumor growth. These interactions between the antihormonal and oncogenic signaling pathways have been termed "crosstalk."

The inhibition of crosstalk has been studied using agents that inhibit only one or two of these pathways (e.g., TAnDEM using trastuzumab with anastrozole and EGF30008 using lapatinib with letrozole). These methods have shown improvement in the progression-free survival but bypass pathways, such as VEGF, eventually develop to lead to further antihormonal resistance.

EVRI has been developed as an orally administered tyrosine kinase inhibitor to inhibit the three most important crosstalk targets, EGFR, HER2 and VEGFR, simultaneously. This inhibition of multiple pathways using one agent will reverse resistance to antihormonal therapy while interfering with the tumor's ability of invasion, survival and development of vascularization.

Product E – Functional Benefits

Benefits in Advanced/Metastatic Non-Small Cell Lung and Metastatic Breast Cancers

- Benefits of clinically validated VEGF inhibition without the need for additional add-on therapies
- Provide patients with an effective, safe and more convenient targeted therapy compared to use of a combination targeted agents or standard cytotoxic therapy
- Restore a patient's quality life without significant economic burden
- Expand the use of targeted therapy for patients who are not eligible for or cannot be effectively treated by other standards of care such as bevacizumab, erlotinib, trastuzumab
- Ability to effectively halt and regress the disease by inhibiting multiple clinically validated oncology targets (EGFR, HER2 and VEGFR) while maintaining or improving quality of life
- Improved adherence/compliance due to convenient oral once a day dosing

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Product E – Functional Benefits

Other Benefits in Non-Small Cell Lung Cancer

- Significantly extend overall survival for NSCLC patients with activating mutations of EGFR tyrosine kinase in all lines of therapy
- Improve progression free survival by 3 months and overall survival by 6 months versus Iressa in 1st line NSCLC with activating mutations of EGFR tyrosine kinase
- Improve progression free survival by 1 month and overall survival by 3 months versus erlotinib in patients after failure of prior chemotherapy, regardless of EGFR mutational status
- The only targeted therapy proven superiority in overall survival in 2nd line+ NSCLC, regardless of EGFR status

Other Benefits in Metastatic Breast Cancer

- Allows ER+ MBC patients with HER2 + or - status to continue on hormone therapy, extending progression-free survival by 5 months, and delaying the need for toxic chemotherapy
- Restore hormone sensitivity to patients while adding the clinical benefit of suppression of VEGF induced tumor angiogenesis
- Maybe this should be maintain hormone sensitivity among ER+ and/or PgR+ BC patients?

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Product E – Reasons to Believe

Product X Can Deliver the Clinical Benefits Because

- May offer the most interconnected or overarching inhibition of tumorigneic pathways
- Offer ability to target EGFR, HER2, and VEGFR mediated resistance
- Allow ER+ BC patients with HER2 + or - status to continue on hormone therapy.
- Delay the need for toxic chemotherapy
- Has unique ability to halt the disease by potently inhibiting multiple molecular drivers (EGFR, HER2 and VEGFR) while maintaining or improving quality of life
- The only agent to effectively and safely combine three clinically validated oncology targets into convenient once a day dosing

15

From: Yoko Okamoto <Yoko.Okamoto@gfk.com>
Sent: Monday, December 14, 2009 6:46 PM
To: Joan Baumer <Joan.Baumer@gfk.com>; Yu, Yue <yue.yu@bms.com>; Guo, Dan <dan.guo@bms.com>; Mcgrath, Holly <holly.mcgrath@bms.com>
Cc: Delghiaccio, Robert <Robert.Delghiaccio@gfk.com>
Subject: GfKHC10194 EVRI Preliminary Positioning Study - Post Kick-Off Debrief
Attach: GfKHC 10194 BMS EVRI Qual NSCLC DG 12 14 09 V9.doc

Hello Everyone,

Please find the attached a copy of the revised DG (NSCLC) – let's discuss during the debrief. BCa version to follow!

Thanks & regards,

Yoko Okamoto
Vice President, Research & Consulting
GfK Healthcare
www.gfkhc.com
587 Skippack Pike
Blue Bell, PA 19422
Phone: (215) 283-3200 ext. 440
Fax: (215) 283-3201
Mobile: (267) 312-3276
Email: yoko.okamoto@gfk.com

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EVRI Preliminary Positioning

- Physician Qualitative NSCLC DG (50 minutes) -

OBJECTIVES :

- **Uncover emotional unmet needs**
- **Uncover functional unmet needs**
- **Gather response to Product Profile to understand the potential to fill the unmet emotional/functional needs**

INTRODUCTION

- Introduction to GfK Healthcare.
- Discussion will be purely for marketing research purposes only and non-promotional in nature. Respondent anonymity will be maintained. Conversation will be tape-recorded for note-taking purposes.
- [In CL IDIs] Colleagues observing behind mirror, via videoconferencing, etc.
- Purpose of discussion: To understand current practices and opinions regarding treatment of NSCLC as well as to evaluate a product profile of a new oncology agent in development.

I. Warm-Up (3-5 minutes)

1) Please tell me a little about your current practice:

2) Please tell me about the type of patients that you serve.
   a) What proportion of your patients is under your care for treatment of NSCLC?
   b) Please describe your NSCLC patient population. **PROBE:** by age groups, gender, socioeconomic background, insurance coverage type.
   ~~c) In terms of the range of tumor types that you treat, how does NSCLC compare? Is it more or less challenging? Why?~~
   ~~d) How about the NSCLC patients themselves, are they more or less challenging than other kinds of cancer patients that you treat?~~
   e) What role, if any, does the patient play in selection of NSCLC therapy? **PROBE:** Based on different educational background, level of family support, other influencers of patient willingness to be treated, etc.
   f) How do you view your relationship to your cancer patients in general? (If necessary, probe on how important it is to get to know the patient, the family, etc. vs. how important it is to maintain a professional distance). Is your approach similar with NSCLC patients?

II. Exploration of Emotional Unmet Needs/Benefits (5 to 7 minutes)

3) I would like undertand more about your experience interacting with your newly diagnosed, or newly progressed, stage III and IV NSCLC patients – now that they are under your care, requiring treatment of the lung cancer, please walk me through the thoughts you may have as you interact with the patient. Here I have a diagram – I would like you to fill out each of the bubbles to describe your interaction with newly diagnosed/progressed stage III/IV NSCLC patients. **HAND THE BUBBLE DIAGRAM TO THE RESPONDENT**
[FOR EACH BUBBLE, ASK]
   a) Please explain your response. Why did you put this response down in this bubble? What triggers these thoughts/feelings? **[MODERATOR: THIS IS A PROJECTIVE TECHNIQUE TO UNCOVER EMOTIONAL NEEDS AND BENEFITS PHYSICIANS ARE EXPERIENCING TODAY – PROBE AS MUCH AS POSSIBLE TO IDENTIFY EMOTIONS (examples include: "frustration about lack of effective therapies", "sense of discouragement because of short survival", "fearful of severe SE associated with doublet therapy", etc. PROBE REGARDING DISCONNECTS (e.g. Uncover why they might hesitate to say what they are thinking...)**

4) Next, let's fast-forward to 5 years from now. I would like for you to assume that there are more and better therapy options available in 5 years – please repeat the same exercise again. I would like to understand how you envision you will interact with your newly diagnosed, or newly progressed, stage III and IV NSCLC patients in 5 years with better therapies available. **HAND A NEW BUBBLE DIAGRAM TO THE RESPONDENT**
[FOR EACH BUBBLE, ASK]
   a) Please explain your response. Why did you put this response down in this bubble? What triggers these thoughts/feelings?
      i) How did your response change from the last response (today vs. 5 years from now) – and what are the factors that influence the change in your response?
         - How would you describe the "better therapy options"? Why? What would you anticipate these better options influence your interactions with NSCLC patients?
         - With better treatments, would that impact on your emotions? How so? Ultimately, how would you feel if there were better treatments available for your patients?
         - What new treatments can you imagine you might have in the future?

III. Exploration of Functional Unmet Needs/Benefits (40 minutes)

~~5) Next, I would like to talk to you about how you currently manage your NSCLC patients. Approximately what proportion of your patients is currently receiving 1st line monotherapy vs. combination therapy?~~

~~6) Please tell me what factors influence your selection of treatment for your NSCLC patients.~~
~~a) When do you use monotherapy vs. combination?~~

7) Which therapies do you frequently consider for 1st line treatment of NSCLC? **PROBE:** Both chemotherapies as well as biologics
[FOR EACH MENTIONED]
   a) In what circumstances do you select this therapy?
      i) When selecting this therapy, what is your primary treatment objective?
   b) What are the strengths/weaknesses of this therapy?

~~8) Which combination therapies do you frequently consider for 1st line?~~
~~[FOR EACH MENTIONED]~~
~~a) In what circumstances do you select this combination therapy?~~
~~i) When selecting this combination therapy, what is your primary treatment objective?~~
~~b) What are the strengths/weaknesses of this combination therapy?~~

9) Please tell me what factors influence your selection of 1st line treatment for your NSCLC patients?
   a) Tell me what disease characteristics are influential. Why these? [MODERATOR: PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Stage of disease
      ii) Histology
      iii) Biomarker testing (EGFR mutation, EGFR Fishing testing for gene copy number)
         - How frequently do you test your NSCLC patients for biomakers?
   b) How about patient characteristics? Which ones – and why these? [MODERATOR: EXCLUDE INSURANCE COVERAGE; PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Age
      ii) Physical condition/ECOG score
      iii) Willingness to be treated
      iv) Social and economic, education, etc.

10) What are the top unmet needs in the treatment of 1st line NSCLC? **PROBE:** ~~by TNM staging, line(s) of therapy,~~ tumor histology

11) What are the most important factors that you consider when using a new product for 1st line treatment of NSCLC? [MODERATOR: FIRST COLLECT UNAIDED RESPONSE THEN PROBE ON FOLLOWING]
   a) Better efficacy, i.e. improvement in OS or PFS?
      i) How many months of OS or PFS are the good enough to consider?
   b) Fewer side effects
      i) Improved quality of life?
   c) Dosing
   d) Updated treatment guideline
   e) Recommendations
      i) By global, regional and/or local organizations
      ii) Key Opinion Leaders (KOLs) and/or peers?
      iii) Which organization do you consider "the authority" in making recommendations for treatment of NSCLC in your region/country/the world?
   f) What would it take for a new therapy option to become a new treatment of choice? [MODERATOR: IF NOT MENTIONED/SPECIFIED, DIRECT THE CONVERSATION TO 1ST LINE MONOTHERAPY]

"Next, I would like to show you a product profile for a new NSCLC product."

HAND THE 1st LINE NSCLC PRODUCT PROFILE

12) Based on the information presented, what are your initial reactions to Product E?
   a) Which aspects in the product description are most important and compelling to you? Why?
      i) What do you like about this product?
      ii) What are the benefits is Produce E offering?
      iii) Is there anything you dislike?
   b) Based on this profile, please tell me your opinions about:
      i) Efficacy
      ii) Safety and Tolerability
      iii) Dosing / Convenience
      iv) MoA
      v) Other considerations
   c) What aspect of this product makes it unique?

13) What are your opinions about the comparator used in this profile?

14) For what types of patients would you consider using Product E?
   a) Why these patients?
   b) Which treatments are currently used for these patients?

15) For what types of patients would you think Product E would be *un*suitable? Why?

16) What could you imagine this product would replace? Why?
   a) How does this address your unmet needs in 1st line treatment of NSCLC?

~~16a) Earlier, you talked about your feelings regarding current treatment options for NSCLC patients. With Product E available, how would you feel about:~~
- ~~Your role as a treater?~~
- ~~Prospects for these patients??~~
- ~~Having this in your armamentarium~~
- ~~Has Product E addressed your unmet needs? Why or why not?~~

~~16b) How would present this treatment to a patient? What would you say?~~

17) Could Product E become your 1st line monotherapy agent of choice? Why or why not?
   a) **[IF NOT]** What data would you need to see in order for this to become your 1st line monotherapy agent of choice?

SECOND LINE TREATMENT PRACTICES AND UNMET NEEDS

18) When considering 2nd line treatments, what proportion of your patients are on monotheray vs. combination therapy? Please tell me what factors influence your selection of treatment for your NSCLC patients.
   a) When do you use monotherapy vs. combination?

19) Which agent(s) do you frequently consider for 2nd line monotherapy?
   [FOR EACH MENTIONED]
   a) In what circumstances do you select this agent?
      i) When selecting this agent, what is your primary treatment objective?
   b) What are the strengths/weaknesses of this agent?

20) Which combination therapies do you frequently consider for 2nd line?
[FOR EACH MENTIONED]
   a) In what circumstances do you select this combination therapy?
      i) When selecting this combination therapy, what is your primary treatment objective?
   b) What are the strengths/weaknesses of this combination therapy?

21) Please tell me what factors influence your selection of 2nd line treatment for your NSCLC patients?
   a) Tell me what disease characteristics are influential. Why these? [MODERATOR: PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Stage of disease
      ii) Histology
      iii) Biomarker testing (EGFR mutation, EGFR Fishing testing for gene copy number)
   b) How about patient characteristics? Which ones – and why these? [MODERATOR: EXCLUDE INSURANCE COVERAGE; PROBE FOR MORE UNTIL RESPONDENT IS UNABLE TO PRODUCE ANY MORE.]
      i) Age
      ii) Physical condition/ECOG score
      iii) Willingness to be treated
      iv) Social and economic, education, etc.

22) How different are the top unmet needs in the 2nd line treatment of NSCLC (vs. 1st line)? ~~What are the top unmet needs in the 2nd line treatment of NSCLC?~~ **PROBE:** ~~by TNM staging, line(s) of therapy,~~ tumor histology

23) What are the most important factors when you consider when using a new product for 2nd line treatment of NSCLC? [MODERATOR: FIRST COLLECT UNAIDED RESPONSE THEN PROBE ON FOLLOWING]
   a) Better efficacy, i.e. improvement in OS or PFS?
      i) How many months of OS or PFS are the good enough to consider?
   b) Fewer side effects
      i) Improved quality of life?
   c) Dosing
   d) Updated treatment guideline
   e) Recommendations
      i) By global, regional and/or local organizations
      ii) Key Opinion Leaders (KOLs) and/or peers?
      iii) Which organization do you consider "the authority" in making recommendations for treatment of NSCLC in your region/country/the world?
   f) What would it take for a new therapy option to become a new treatment of choice? [MODERATOR: IF NOT MENTIONED/SPECIFIED, DIRECT THE CONVERSATION TO 1st LINE MONOTHERAPY] What would it take for a product to become the new monotherapy agent of choice (i.e. replace Tarceva)?

"Next, I would like to show you a product profile for a new NSCLC product."

HAND THE 2nd LINE NSCLC PRODUCT PROFILE

24) Based on the information presented, what are your initial reactions to Product E used 2nd line?
   a) Which aspects in the product description are most important and compelling to you? Why?
      i) What do you like about this product?
      ii) What are the benefits Produce E offering?
      iii) Is there anything you dislike?
   b) Based on this profile, please tell me your opinions about:
      i) Efficacy
      ii) Safety and Tolerability
      iii) Dosing / Convenience
      iv) MoA
      v) Other considerations
   c) What aspect of this product makes it unique?

25) What are your opinions about the comparator used in this profile?

26) For what types of patients would you consider using Product E 2nd line?
   a) Why these patients?
   b) Which treatments are currently used for these patients?

27) For what types of patients would you think Product E would be *un*suitable? Why?

28) What could you imagine this product would replace? Why?

29) Could Product E become your 2nd line monotherapy agent of choice? Why or why not?
   a) **[IF NOT]** What data would you need to see in order for this to become your 1st line monotherapy agent of choice?

30) Now you have seen two profiles (1st line vs. 2nd line) – how would you envision you will use Product E? PROBE: 1st line vs. 2nd line, in what patient types, etc.
   a) Why do you say that?

V. Closing Questions

MODERATOR: Check with back-room team to see if they have any additional questions.

EXHIBIT L

From: Guo, Dan <dan.guo@bms.com>
Sent: Saturday, December 12, 2009 5:18 PM
To: Sbar, Eric <eric.sbar@bms.com>; Cheng, Shinta <shinta.cheng@bms.com>; Salvati, Mark <mark.salvati@bms.com>; Yu, Yue <yue.yu@bms.com>
Subject: RE: Positioning questions

Hi Eric, All-

Holly/Yue tried to cut down the questions to focus only key ones. In light of the interview time (50mins), the previous version is too ambitious.

Dan

From: Sbar, Eric
Sent: Friday, December 11, 2009 3:09 PM
To: Guo, Dan; Cheng, Shinta; Salvati, Mark; Yu, Yue
Subject: Positioning questions

Hi Dan,

Are we going to see the final version of the questions for next week's positioning meeting? If we are, we do not have a lot of time to clarify any problems that were in the previous question sets.

Eric

Sbar, Eric
Director
Global Clinical Development

609-252-4249 Work
215-266-9070 Mobile
eric.sbar@bms.com
Route 206 and Province Line Road
Mail Stop 3 22-01
Princeton 08543

Subject: EVRI Preliminary Positioning Kick-off meeting

Location: CR-B3-468/telecon.

Start: 10/1/2009 11:00 AM

End: 10/1/2009 12:00 PM

Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Required Attendees: Kozick, Linda; Guo, Dan; Hunt, William; Sbar, Eric; Mcgrath, Holly

Resources: CR-B3-468/telecon.

When: Thursday, October 01, 2009 11:00 AM-12:00 PM (GMT-05:00) Eastern Time (US & Canada).

Where: CR-B3-468/telecon.

Note: The GMT offset above does not reflect daylight saving time adjustments.

~~*~*~*~*~*~*~*~*~*

All,

The objective of this meeting is to brainstorm the scope and objective for the research project.

Thanks,

Yue Yu

US Dial-In #: 866-217-3840

International Dial-In #: 816-249-4608

Conference Code: 6092523795

EVRI SO

From: Mcgrath, Holly <holly.mcgrath@bms.com>
Sent: Friday, December 11, 2009 5:12 PM
To: Wilson (PLB), Rob <rob.wilson@bms.com>; Delghiaccio, Robert <Robert.Delghiaccio@gfk.com>; Yu, Yue <yue.yu@bms.com>
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

Robert -- u da best!

From: Wilson (PLB), Rob
Sent: Friday, December 11, 2009 4:10 PM
To: Delghiaccio, Robert; Yu, Yue
Cc: Mcgrath, Holly
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

All,

The service order number for the XL184 project is 81032845. Finance has assure me that the service order for ENVI will be in my inbox first thing Monday, morning. Have a good weekend and thank you, for your patience.

P.S. Thanks to Holly McGrath for cutting thru the red tape.

From: Delghiaccio, Robert [mailto:Robert.Delghiaccio@gfk.com]
Sent: Friday, December 11, 2009 12:51 PM
To: Yu, Yue
Cc: Wilson (PLB), Rob
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

Hi, Yue—I just tried to give you a ring on the phone number below, and the call went straight to VM. I did not leave a message, so please give me a ring—I am in the office (973.599.3985).

My understanding is that Jeney Joseph approved the SO last Friday (12/4), and it now just needs to be inputted into the Mercury system. Suppliers used to have access to Mercury earlier in the year, but not any longer.

Again, I am in the office if you would like to speak.

Thanks,

Rob

Make your challenge ours! Click here to get an actionable answer to your most pressing question – exclusively derived from our dataset across the categories we serve – at no cost to you.

Rob Delghiaccio
GfK Healthcare
P: (973) 599-3985
C: (973) 652-7770

Marketing Research Built for You

Flexible resources, responsive to your evolving challenges

From: Yu, Yue [mailto:yue.yu@bms.com]
Sent: Friday, December 11, 2009 12:23 PM

From: Yu, Yue <yue.yu@bms.com>
Sent: Monday, December 14, 2009 1:59 PM
To: Wilson (PLB), Rob <rob.wilson@bms.com>; Delghiaccio, Robert <Robert.Delghiaccio@gfk.com>
Cc: Mcgrath, Holly <holly.mcgrath@bms.com>; Slayton, Dolores <dolores.slayton@bms.com>
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

---

thank you very much.

From: Wilson (PLB), Rob
Sent: Monday, December 14, 2009 1:49 PM
To: Delghiaccio, Robert; Yu, Yue
Cc: Mcgrath, Holly; Slayton, Dolores
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

All,

As promised, even though it's noon - here is the service order number for the EVRI Project: **81033337**

Rob

From: Delghiaccio, Robert [mailto:Robert.Delghiaccio@gfk.com]
Sent: Friday, December 11, 2009 4:23 PM
To: Wilson (PLB), Rob; Yu, Yue
Cc: Mcgrath, Holly
Subject: RE: EVRI Preliminary Positioning Market Research Service Order

Thanks so much, Rob. Looks like we are good to go. We appreciate your follow up on this.

And of course, thanks Holly for working your magic...

Take care,

Rob

Rob Delghiaccio
GfK Healthcare
P: (973) 599-3985
C: (973) 652-7770

From: Wilson (PLB), Rob [mailto:rob.wilson@bms.com]
Sent: Friday, December 11, 2009 4:11 PM
To: Delghiaccio, Robert; Yu, Yue
Cc: Mcgrath, Holly
Subject: RE: EVRI Preliminary Positioning Market Research Service Order
Importance: High

From: Mcgrath, Holly <holly.mcgrath@bms.com>
Sent: Tuesday, December 15, 2009 8:41 PM
To: Yu, Yue <yue.yu@bms.com>
Subject: RE: Give me a call

Sorry we haven't been able to connect. We'll talk when you're back....I think you're doing a good job, Yue. This has been a tough project for a variety of reasons, and we'll talk more about that. But I didn't want you to worry.

Holly

From: Yu, Yue
Sent: Tuesday, December 15, 2009 5:12 PM
To: Mcgrath, Holly
Subject: RE: Give me a call

Hi, Holly,

Hope your day went well.

I left a VM to you this morning. I am in Chicago and please call me if you need to discuss.

973-801-3919

best regards

Yue

From: Mcgrath, Holly
Sent: Tuesday, December 15, 2009 9:22 AM
To: Yu, Yue
Subject: Give me a call

Whenever you get the opportunity - I'm in the office.

Bristol-Myers Squibb
Marketing Research Director, Global Oncology
Ph 609-252-3795
holly.mcgrath@bms.com

From: Salvati, Mark <mark.salvati@bms.com>
Sent: Wednesday, November 25, 2009 3:13 PM
To: Yu, Yue <yue.yu@bms.com>; Sbar, Eric <eric.sbar@bms.com>; Guo, Dan <dan.guo@bms.com>; Cheng, Shinta <shinta.cheng@bms.com>; Johnson, Lisa <lisa.johnson@bms.com>; yueyu88@hotmail.com
Subject: RE: EVRI Preliminary Positioning MR Meeting follow up
Attach: NSCLC TPP July 28 2009 MESS.ppt

Yue

I have held off sending my comments on the market research documents because I wanted to meet with the individuals from the team to discuss their concerns around the current product profile document.

From my discussions with the team, the main concern stems from the fact that the current product profiles are highly detailed and contain more information around the profile of the competitor product than EVRI. In addition, the key efficacy data is a minor component of the table and on the second page of the document. The concern is that the Physicians (who often do not read over the materials until just before the interview), will be put off by such a detailed document and not pay attention to the key data sets on EVRI.

I reviewed several product profile documents created for the Ixa program with Eric, Shinta and Dan and we identified a simplified approach that we all feel more comfortable with. I have attached an example deck that we can work from (these were used by Gfk for our Ixa NSCLC market research this year). The information needed for this simplified deck is all contained in the current product profile sheets you created; we just need to reformate it into a simple set of slides. We should focus on the key clinical endpoints from the trial and a few of the key toxicity issues for each arm of the trial. From my experience, physicians seem to respond better to these simple schemas than to a detailed document. Once we have them clear on the efficacy and the tox points we can add specific questions around detailed aspects of the drug.

Over the weekend I will put together a set of simple talking points to guild the product profile deck (similar to the example deck attached). We need to ask the vendor to create new simplified schema and then the team needs to update the slides with the most recent efficacy estimates based on discussions today.

I would like to recommend that we keep the current product profile sheets as back-up material for those physicians who want additional information beyond the simple schema based slides. This would include the MOA slide as the very last page of the overview documents.

Thank you

Mark

From: Yu, Yue
Sent: Wednesday, November 25, 2009 12:15 PM
To: Sbar, Eric; Guo, Dan; Cheng, Shinta; Salvati, Mark; Johnson, Lisa; yueyu88@hotmail.com
Subject: RE: EVRI Preliminary Positioning MR Meeting follow up
Importance: High

Dear all,

I want to provide explanation and suggestion for the approach of the Stimuli development.

The stimuli are divided into two categories:

1. Clinical and medical stimuli (which include product profiles--NSCLC and MBC; the MOA diagram)
   - The Profiles will be presented during the research.
   - The MoA diagram will NOT be presented during the research. However, the MOA is beneficial for providing additional knowledge for the research moderators.
   - Clinical and medical lead this part of the Stimuli development
2. Marketing stimuli (which include product features, functional benefits and reasons to believe)
   - We had several meetings to go over the features and functional benefits
   - The list of features and benefits should be factual based; not inspirational
   - Reasons to believe is derived from the Statements provided by Marketing
   - Marketing team lead this part of Stimuli development

I would suggest the following steps in order to move the Project forward:

- Shinta, Eric and Mark work together to finalize the Product Profiles
- Dan take the lead on the Marketing Stimuli development
- Yue leads the Discussion Guide development and coordinates with MR vendor to translate the Stimuli and discussion guide, review translation, etc.

Please let me know if you have any questions or concerns.

On a separate note, I will be in China from Nov. 27 to Dec. 8. I will have email access and continue to work on the research projects. Please communicate with me as I were at the office. please copy my personal email just in case.

Thank you all and have a happy Thanksgiving

Yue

From: Sbar, Eric
Sent: Tuesday, November 24, 2009 11:40 AM
To: Yu, Yue; Guo, Dan; Cheng, Shinta; Salvati, Mark; Johnson, Lisa
Subject: RE: EVRI Preliminary Positioning MR Meeting follow up

Hi Everyone,

I am attaching my comments but I feel that these documents need more work. Some of them, like the Features, Functional Benefits and Reasons to Believe don't make a lot of sense to me. Please make a suggestion about how we can move this forward. I also do not feel that any information regarding crosstalk or the diagram of MOA for EVRI is of any benefit.

Thanks,
Eric

From: Yu, Yue
Sent: Thursday, November 19, 2009 7:00 PM
To: Guo, Dan; Sbar, Eric; Cheng, Shinta; Salvati, Mark; Johnson, Lisa
Subject: EVRI Preliminary Positioning MR Meeting follow up

Dear all,

As we discussed, the attached materials are for your review. Please provide your feedback to me as your earliest convenience so that we can finalize the stimuli and start to the translation process.

The Reasons to believe: I take them from Dan's Statements; please add more if possible

I also include the Diagram with the Statement done by Eric. I would like to use this to educate the moderators. Please provide your comments on the Diagram and Statement.

Best regards

Yue

EXHIBIT M

The following is an outline of how things transpired:

- **January 6, 2010**, MR Global Oncology Staff Meeting
  - During the meeting, Dan Stults, Sr. Director, MR announced a headcount had been granted to oncology global market research group under Holly McGrath's management.
  - Dan further comments there the open headcount would impact the length of Yue's assignment and Holly would keep the communication open.

- **January 12, 2010**, One-on-One (Holly and Yue)
  - During the meeting, Yue asked the impact of the full time position on Yue's assignment.
  - Holly's response was that she did not know when the position would be filled. She implied Yue's assignment would be concluded after the full time position is filled.
  - Then, Yue asked whether she could be considered for the full time position. Holly responded without hesitation, "Of course, I am open for it. You will be placed into the candidate pool to go through the interview process. Only one condition, if there is no provision in your contract which prevents you from being hired by BMS. Check with Rob Delghiaccio from GfK Healthcare."

- **January 12, 2010**, telephone discussion with Rob Delghiaccio
  - Yue told Rob that she was interested in pursuing the full time position with Holly's group and inquired any provision which would prevent Yue from pursuing the position.
  - Rob told Yue there was no provision in the Contract and he 100% support Yue's effort of pursuing the position.
  - Rob told Yue that he would discuss the opportunity with Dan Stults over lunch.
- **January 19, 2010**, Rob requested to follow up with you regarding the full time position. The meeting was scheduled at 8:30AM on Jan. 20, 2010.

- **January 20, 2010**, Teleconference with Rob Delghiaccio
  - Rob told me that he had a discussion with Holly regarding Yue pursuing the full time position.
  - To his surprise, Holly informed Rob that Dan Guo, Director, EVRI marketing, asked Holly to remove Yue from EVRI market research and asked Basya Gale, the former consultant to take on market research projects.
  - Holly told Rob that the statement would come as a surprise to him and Yue.
  - Holly told Rob that Yue has exhibited skills of a strong market researcher and Holly had no doubt that Yue will continue to do a good job.
  - However, Holly commented that it would be a lost battle if marketing team members don't want Yue to be at BMS.
  -

- **January 25, 2010**, Yue talked to Dan. Yue asked feedback from Dan regarding her work. The feedback was positive. Then, Yue informed Dan about the request to remove Yue from EVEI market research. Dan was surprised and he stated that he had not contacted Holly regarding the EVRI research since December 2009.
- **January 25, 2010,** Yue learned that Holly scheduled a meeting with Dan, subject: EVRI MR update. There was no need to update EVRI market research.

- **January 28, 2010**, Yue met with Holly
  - Performance was good. But need to knowledge the requests from Holly by reciting the requests instead of saying "yes, I understand."

- **February 2,** Yue met with Holly
  - Comment, Yue has to show Holly the work requested by the brand team i.e. secondary analysis.
  - However, Holly had been informed about the data analysis requests from brand team on weekly basis. She never requested to see the product.

- **February 12, 2010,** BMS update with Rob D. per his request
  - Rob called Yue to discuss the update with BMS.
  - Yue told Rob that she was interested in pursuing full time positions with BMS including the one with Holly's group.
  - Rob first commented, "why not?", then, he asked Yue whether Yue would be comfortable with Holly?
  - Yue's response was "the devil you know is better than the devil you don't know." Yue further explained that it applied to both Holly and Yue. There might be a little disconnect between Holly and Yue; however, it largely based on the different personal styles and could be easily fixed.

- **February 17, 2010**, "reconvene- review ER+ data corresponding to Breast TSG key questions"
  - Susan Heinberg, Jamie Foley, Denise Pettiecord attended the meeting
  - At the beginning of the meeting, Susan told me that she just heard that Yue was leaving BMS.
  - Susan commented that she has been very satisfied with Yue's work. She stated that the several projects Yue has worked on have been great, timely and professional. She was very grateful and did not want Yue to leave BMS.
  - Later, Jamie asked when Yue was leaving. Yue told Jamie, Susan and Denise that Yue was interested in pursuing
- **March 1, 2010,** Yue sent an email message to request Holly to consider Yue for the full time position and Yue also applied the Position on www.bms.com
  - Holly responded to discuss the matter in person

- **March 4, 2010**, Yue discussed the full time position with Holly.
  - Holly was upset that Yue applied the Position online and she informed the BMS staff manager not to consider Yue's candidacy.

- Holly further commented that market team members provided negative feedback about Yue's performance and she can't allow Yue to go through interview process
- Holly further commented that the candidates whom she interviewed were more qualified than Yue.
- Holly informed me that she declined to offer interview opportunity to Yue in light of the recommendation from the staff personnel. Holly told Yue that she informed the staff manager "Yue was not qualified."
- When Yue asked the reasons she did not want to consider Yue's candidacy, she responded, "there are reasons". When Yue pressed Holly "Is that because I am a Chinese?" Her body language and facial expression told me that being a Chinese was a factor for not being considered for the position Yue applied.

- **March 8, 2010** Holly cancelled all one-on-one meetings with Yue, however, the hostile attitude Yue and harassment continued.

1:1 with Holly 1/12/2010

- Head Count

- XL 184 MR
  - change { objectives → ~~DG~~ → link between MoA and value prop
    stimuli ⇒ delay Germany.
  - under control.

- Data requests
  - lung TSG
  - Breast TSG
- Data purchased analysis

→ EVRI → report review with Holly

EXHIBIT MC

From: Delghiaccio, Robert <Robert.Delghiaccio@gfk.com>
Sent: Monday, March 22, 2010 3:39 PM
To: Mcgrath, Holly <holly.mcgrath@bms.com>
Cc: Okamoto, Yoko <Yoko.Okamoto@gfk.com>
Subject: XL-184 Frame of Reference Study

Hi, Holly—

I made it down to Philadelphia for the Sprycel testing (Rishabh says hello), and we are in between interviews at the moment, so I thought I would follow up to my VM to you from a short time ago.

In sum, Yoko and I spoke, and will be prepared tomorrow to take the lead in the discussion, with a particular emphasis on the key *strategic take-aways* (i.e., executive summary and conclusions/recommendations) that you can take to the brand team which can provide guidance on how to leverage the potential for the XL-184 brand in the various solid tumor markets of focus. I know that you are acutely aware that MOA in and of itself is not a driver of use—it is whether or not the product is perceived efficacious and safe. Notwithstanding, there are other issue beyond MOA that lead to opportunities specifically related to each potential indication for XL-184 that we will discuss.

As you know, the brand team had taken a decided focus on the perceived value of MOA for this research. That said, there are other take-aways from the research that we can elucidate for you.

I have also made Yue Yu aware of the plan for the GfK Team to take the lead tomorrow to discuss conclusions/recommendations, and we can then subsequently and collectively discuss which conclusions/recommendations should be in the final presentation.

Lastly, Yoko will be sending the set of slides for your review prior to our meeting tomorrow. This will provide you with a template prior to our discussion tomorrow afternoon.

Take care, and please let me know if you have any questions.

Regards,

Rob

Rob Delghiaccio
Senior Vice President
GfK Healthcare
120 Eagle Rock Avenue
East Hanover, NJ 07936
P: (973) 599-3985
F: (973) 599-3690
C: (973) 652-7770
robert.delghiaccio@gfk.com

From: Orosz, Jill <jill.orosz@bms.com>
Sent: Wednesday, February 24, 2010 11:03 AM
To: Mcgrath, Holly <holly.mcgrath@bms.com>
Cc: Ross, Adrienne <adrienne.ross@bms.com>
Subject: RE: MR Consultant - Feedback needed
Attach: XL184.ppt

Hi Holly,

1. Completion of MOA research (final report/presentation). As you note, Yue may be finishing this project since she had started it. But, just wanted to highlight it.

2. See attached. There are several project for the remainder of the year, so we will need a resource (Yue or other) to assist. Some of these may change slightly, but the funds and projects themselves remain in our plan. I'm finalizing SOW with our agency, and will have the final MR soon.

I hope this helps

Jill

> **Sent:** Wednesday, February 24, 2010 8:59 AM
> **To:** Foley, Jamie; Heinberg, Susan; Guo, Dan; Orosz, Jill
> **Cc:** Ross, Adrienne; Kozick, Linda
> **Subject:** MR Consultant - Feedback needed
>
> Hi all -
>
> We have been fortunate to be able to fund our MR consultant thru credits that we had earned with a marketing research vendor, but those credits are now coming to an end. If we are to continue into March and beyond we will need to pay for the consultant thru our MR budget. If we decide not to continue, please be assured that all currently active projects will be brought to conclusion before Yue's time here ends.
>
> Please email me back with your thoughts on continuing Yue's assignment and what projects you would have her working on.
>
> Best -
>
> Holly
>
> *Bristol-Myers Squibb*
> *Marketing Research Director, Global Oncology*
> *Ph 609-252-3795*
> *holly.mcgrath@bms.com*

XL184 Frame of Reference Qualitative Market Research – Final Report

Global Market Research
March, 2010

Table of Content

Background

- XL184 is a compound that targets MET, VEGFR2 and RET
- There are numerous ongoing clinical trials for XL184:
  - GBM: Phase II, Phase I
  - MTC: Phase III, Phase I
  - NSCLC: Phase II
- New Trial: Phase II Study of XL184 in Adults with Advanced Malignancies started in August 2009
  - The objective of the trial is to determine whether XL184 has anti-tumor activities in selected nine tumor types

Business Issues

- Previous market research has been GBM focused and Avastin was the main consideration for competitive landscape
- The competitive frame might be different for XL184 when considering other types of tumors outside GBM
- The business questions are:
  - Who are the competitors outside GBM for XL184?
    - Are the competition sets across multiple types of tumors different?
    - Is the value proposition/perception of XL184 different in different tumors (i.e. different frame of reference)
  - Whether is there a link between MoA and a product's value proposition

Research Objectives
&
Methodology

Objectives

- To understand any link between MoA and value proposition within the varying tumor types
  - How much, if any, does MoA matter within each indication—does it matter more or less in any indication? Are there perceptual motivators or barriers
- To obtain physicians' assessment and value proposition of XL184 in gastric, prostate, NSCLC and Head & Neck cancers
  - Overall impression & exploration of drivers (efficacy, MoA, safety profile) and barriers for use
  - Obtain physicians' understanding and perception of XL184:
    - Discussion of MoA and how it relates to perceived benefits (efficacy, tolerability, etc.)
    - Use comparator's TPP to stimulate the discussion of link between MoA and value proposition
    - Determine whether these links are different in different tumors
- Understand physicians' perceptions of the competitive landscape/unmet needs in selected tumors – Gastric, NSCLC, Prostate, Head and Neck

Research Methodology

- Primary, in-person in-depth interviews with physicians from US and Germany. Each respondent is interviewed with one of the four tumor combinations:

Tumor Combination Group	Oncologists	US	Germany, Germany	
1	Gastric & NSCLC	4*	3	
2	HRPC & SCCHN	5*	2	
3	Gastric & SCCHN	6*	2	
4	HRPC& NSCLC	2*	2	
	Total	17	9	26

<u>All respondents met the following criteria:</u>

- Board certified or board eligible in oncology (in the US)
- In practice between 3 to 30 years post-residency
- Personally treat a minimum number of patients per month:
  - All groups: 5 Gastric Cancer
  - Group 1 and 4: 10 Non-Small Cell Lung Cancer (NSCLC)
  - Group 2 and 4: 10 Hormone Refractory Prostate Cancer (HRPC)
  - Group 2 and 3: 12 Head and Neck Cancer (SCCHN)

*Ft. Lauderdale: Gp. #1: Gastric, GBM, NSCLC; Gp.#2: Gastric, NSCLC, SCCHN; Gp. #3: Gastric, SCCHN, HRPC; No Gp. #4

Executive Summary

Key Learning

- Across all the four tumors discussed, the drivers of clinical usage and interests are efficacy and safety; not MoA
  - Physicians don't relate MoA to the product's proposition
- Majority of the physicians interviewed were not interested in the MoA; while minority thinks MoA is intriguing
- Lack of familiarity of the pathways XL184 addresses is one of the reasons that physicians didn't engage in MoA discussion
- Physicians who engaged in MoA discussion exhibit more interests in the more difficult to treat cancers such as Gastric
  - Level of difficulty to treat the disease drives the interest, but not the MoA per se
- Gastric cancer has the greatest unmet needs among the four types of tumors discussed

Detailed Findings

Non-Small Cell Lung Cancer

XL184

Chemo Doublet is the Gold Standard While Alimta Gains Popularity in the Treatment of NSCLC

- Chemo doublet therapy is the gold standard treatment in NSCLC
  - Carboplatin + paclitaxel is the most common doublet regimen in the US
  - In contrast, German physicians prefer cisplatin-based doublet therapy because of its perceived superior efficacy carboplatin.

- In the U.S., Alimta (pemetrexed) is gaining popularity in 1st line use in non-squamous NSCLC
  - Alimta is considered to offer a better tolerated side effect than other treatments and is frequently added to a chemo doublet regimen
  - Alimta is mostly used in combination with carboplatin
  - Some physicians also use Alimta as mono therapy in 1st line

"There's a 60% response rate with carbo-taxol. It works, It is cheap, and it is well-tolerated." Onc, US

"Platinum based doublet is the standard." – Onc, Germany

Adding Target Agents to the Chemo Doublets Has Been Established in 1st L; Tarceva is Used as Monotherapy

- Most physicians use target therapy in combination with chemo doublets in 1st line NSCLC treatment
  - Target agents add additional efficacy to chemo therapy
  - However, the target therapy won't replace standard chemo therapy unless successful clinical trials to demonstrate efficacy
  - In the US clinical practice, chemotherapy combined with target therapy comprises about 25% of total 1st line regimen; Europe has a smaller percentage (6%) of target agent and chemo combination*
- In the US, Avastin (bevacizumab) was often mentioned to be the target agent added to chemo therapy
  - However, the side effects of Avastin limit its usage
- Tarceva is sometimes used as mono therapy in the 1st line setting:
  - Poor performance status patients
  - EGFR mutant patients

* source: IntrinsiQ Research and IMS Oncology Analyzer

"If they are at risk of a stroke, there is no Avastin." – Onc, US
"I haven't used Erbitux…I would only use it if the patient is not a candidate for Avastin. The results are not as impressive as Avastin….if squamous, maybe…" – Onc, US

NSCLC Patients Factors Influence Treatment

- The typical NSCLC patient is described as being in their 60s or 70s, often male, and a smoker
  - There is a minority of non-smoking, female, Asian, and EGRF mutant patients who do not fit this stereotype

- Patient characteristics that influence therapy selection include:
  - Co-morbidities
  - Performance status
  - Histology (Squamous vs. Non-squamous)
  - EGFR mutation
  - Patient Preference (e.g. preference for no hair loss)

"Targeted therapies will play a larger role - EGFR mutation is a good predictor." – Onc, Germany

MET and RET are Unfamiliar and Confusing for Most; Unable to Relate MoA to Efficacy

- Very few of the respondents in the U.S. and none of the respondents in Germany are familiar with MET or RET
- Most physicians don't relate MoA to efficacy
- At least half of the respondents have no interest in the MoA, focusing exclusively on efficacy, safety, and dosing/administration
- In the U.S., few physicians found the MoA to be intriguing, interesting or logical, but not fully understandable
  - One respondent described it as an oral Avastin

"This is like an oral Avastin…it targets VEGFR…MET is interesting…I would not use it, however, unless it is proven to be better than Avastin." - Hem Onc, US

"The MoA is more common than "T" (the comparator) - I am not sure how to relate the MoA to the efficacy endpoints on my own, but the argument is certainly agreeable." - Onc, Germany

"MET expression and activation is fascinating, but it doesn't matter. (I am looking for efficacy and safety.)" - Hem Onc, US

Tepid Response to XL184 Product Profile

- Physicians consider the efficacy offered by XL184 modest at best and it is not appealing
- Most physicians from the U.S accepted the safety profile; whereas, in Germany, the safety profile is seen as slightly more toxic than that of the comparator
  - Concerns about diarrhea surfaced in Germany
- XL184 does not stand out as superior to current offerings
  - There are target therapy choices in NSCLC
- The oral formulation receives nixed views
  - It is convenient; but may pose compliance issues
  - It reduces financial income for physicians vs. IV form

"This is similar to Avastin data." - Hem Onc, US

"Not very convincing… looks like something we have already. Not ground breaking…" – Onc, Germany

The safety profile is acceptable here - not favorable per se, but tolerable." - Onc, Germany

Gastric Cancer

[redacted]

XL184

Gastric Cancer is Considered one of the Most Difficult to Treat and Herceptin Offers Some Hope

- Gastric Cancer has the greatest need for new treatments
  - Current treatments are limited and chemotherapies don't generate good response rate
  - No target therapy is approved to treat gastric cancer*
- Herceptin brings excitement and hope to physicians
  - Several Physicians are aware of Herceptin clinical trial and awaiting for its approval
  - Although there are few HER2-positive gastric cancer patients in their practices, physicians expressed interest in prescribing Herceptin
- * *On Jan. 28, 2010, Roche announced Herceptin in combination with chemotherapy is approved by EU to treat HER2 positive metastatic stomach (gastric) cancer*

"There is HER2 data and it impacts maybe 30% of patients…TKIs will probably be used. I haven't prescribed Herceptin yet…looking forward to it…haven't found the right patient." - Med Onc, US

"There is no one good agent. The only thing that is new is Herceptin." - Hem Onc, US

"(Herceptin) is a new trend. Using Herceptin based on a HER2 status patient. I have not used it but (if I found this) mutation status, I would probably start to use it…" - Onc, Germany

No Typical Gastric Cancer Patients

- Most commonly used in 1st line treatments:
  - High performance patients: EOX chemotherapy (epirubicin, oxaliplatin, and capecitabine) or ECF chemotherapy (epirubicin, cisplatin, and fluorouracil)
  - Poor performance patients: oral Zeloda
- There is no typical gastric cancer patient
  - The majority claim there are no clear demographics, but all of the patients suffering from this disease are very sick and malnourished
  - Some physicians see more elderly patients, while others have some young male patients
- Patient characteristics that impact on treatment selection include:
  - Performance status
  - Ability to swallow
  - Willingness to be treated

"This cancer is not as chemo sensitive (as others) and triple therapy is pretty rough…terrible side effects and supplemental feeding is needed." - Hem Onc, US

"There really are no active drugs for these patients and they are young." - Hem Onc, US

US Physicians Exhibits Higher Interests in MoA in the Gastric Cancer than Other Cancers

- Reaction to the MoA is more positive in the U.S. than in Germany due to its novelty and multiple targets
  - Part of this interest could be related to the hope for an efficacious treatment for these needy patients
- Physicians seem to be more familiar with XL184's comparator's MoA
  - However, the comparator is seen as just another Avastin
  - There is no great enthusiasm for the comparator's MoA, just familiarity
- In Germany, there is generally less interest in the MoA and more resistance to a discussion than in the U.S.

"I have been looking at MET for a while…this presents an interesting adjunct." - Hem Onc, US

"This is more targeted. It is new and exciting…more of a selling point." - Hem Onc, US

[redacted]

XL184

Efficacy is Only Fair, but Strong Need for Treatment Improvement Drives Interest in Discussion

- Since Gastric Cancer does not respond well to chemotherapy and there is a high mortality rate, XL184 is received with some enthusiasm
- Efficacy is seen as fair, but not overly impressive
- Safety is considered acceptable, however, diarrhea, hand and foot syndrome, nausea and vomiting are noted as concerns
- Once a day dosing is not a great benefit because this is combination therapy

"Efficacy is good, but not that impressive." - Hem Onc, US

"It seems to provide good efficacy endpoint improvements." - Onc, Germany

"It is like Xeloda - hand and foot syndrome is a concern… can be serious. GI side effects are not unusual." - Onc, Germany

Hormone Refractory Prostate Cancer

Clinical Practices of Urologists Impose Treatment Barrier to the Patients

- Urologists are the physicians who routinely diagnose the disease
  - Most of them treat patients until those patients no longer respond to hormone treatment
- Prostate cancer patients referred to oncologists
  - 75-80 years old
  - Had surgery in the past
  - Have significant co-morbidities
  - Many have metastatic cancer
- The delay in referring prostate cancer patients to oncologists is frustrating for most oncologists
  - It would be too late to offer much meaningful treatment by oncologists
  - It is changing since urologists desire to get the patients on Taxotere earlier than before
- The key patient characteristic that influences therapy selection is tolerance

Superior Efficacy to Taxotere is a Powerful Asset

- Physicians are interested in XL184 due to its superior efficacy to Taxotere
  - There are few options available for these patients that the efficacy is a strong draw
  - The significant improvement offered by XL184 generates much interests in its novel MoA.
- Efficacy is described as better than offered by the existing therapy
- Safety is considered acceptable, but there are concerns about diarrhea and hand and foot syndrome

"Versus Taxotere, this is a big leap forward in terms of overall survival (3 months vs. 8 months)." – Onc, Germany

"This has superior efficacy over Taxotare." – Onc, Germany

"Toxicity is, well, present….but acceptable." – Onc, Germany

Great Unmet Needs in HRPC

- HRPC is considered difficult to treat; the 2nd difficult to treatment cancer right behind Gastric Cancer
- Taxotere is commonly used 1st line in the U.S. and it is exclusively used in Germany primarily because it is the only agent approved for this type of cancer
  - In the U.S., for those who cannot tolerate Taxotere, Carboplatin is used
- There is no biomarker testing done because there is no targeted therapy being used for HRPC at this time
  - However, in Germany, physicians expect Avastin will soon be approved
- Greatest unmet needs:
  - Better rate of response
  - Less toxic options
  - More treatment options

"They get Taxotere every 3 weeks. It works on 40-50% of the patients. As they progress, there are no other drugs. Maybe they get a benefit for 9-11 months and then it stops." - Med Onc, US

"Taxotere is only effective in 50% of the patients… overall survival is 3 months, give or take… Efficacy is pretty unsatisfactory." - Onc, Germany

XL184

Although Physicians Resist to Engage in MoA Discussion; the Reaction is Positive

- Both in the U.S. and in Germany, there are objections to a MoA discussion related to HRPC
- Overall reaction to X184's MoA, however, is generally positive due to its novelty
- XL184 stands up well against its comparator due to its novel action

"MET is different. I don't know this." - Hem Onc, US

"There is nothing meaningful I can say here… given my knowledge of MoA - and really, these things matter in development of compounds… but not in clinical setting." - Onc, Germany

"VEGFR is a known MoA. Like Avastin, it may have similar problems with proliferation… nose bleed…. It is definitely NOT for the elderly." - Onc, Germany

"This is an Avastin-type drug with similar side effects. This is not much different than Avastin…same side effects and MoA." - Hem Onc, US

Head and Neck

Acceptable Treatment Options

- Physicians consider the treatment options are acceptable
  - In Germany, the most common 1st line treatment is Cisplatin plus 5 FU in addition to cetuximab (Erbitux).
  - In the U.S., there is no clear 1st line treatment, however, certain combinations were frequently mentioned
    - Carboplatin or Cisplatin and radiation
    - Erbitux and radiation

- Erbitux is the most used Targeted agent
  - Erbitux is used more heavily as a 1st line agent in Germany than in the U.S.
    - In the U.S., it is used on older and more frail patients and for relapsed patients
    - In general, U.S. physicians do not test for EGFR before prescribing Erbitux because:
      - There are no guidelines
      - Physicians want to have more treatment options

It (Cisplatin and 5 FU) is well tolerated for the most part… and there is some efficacy." – Onc, Germany

"The treatment options are bad…surgery…radiation…and chemo." - Hem Onc, US

"I will give cisplatin and taxol if they can handle it." - Hem Onc, US

Unmet Needs for Less Toxicity and Increased Overall Survival

- Unmet needs include:
  - Improved efficacy i.e. at least a 3 month increase in overall survival
  - Less side effect

"In the case of relapse, I want a prolongation of survival without increasing toxicity. OS improvement of 3 mo. Would be appealing." – Onc, Germany

Patients Factors Influence Treatment Choice

- The typical SCHHN patient is middle-aged with a history of smoking and/or heavy alcohol consumption
- Patient characteristics that influence therapy selection:
  - Performance status / overall health
  - Bulkiness of the tumor
  - Patient preferences (e.g. avoid hair loss)
  - Financial considerations impact the selection of Erbitux

"They (SCCHN patients) are typically men, middle aged, nicotine and/or alcohol abuse history." - Onc, Germany

"They are middle-aged…late 50s or 60s and heavy smokers." - Hem Onc, US

MoA Seen as Novel Due to MET, Efficacy Still the Key

- In Head and Neck Cancer, the MoA is seen as novel due to the understanding of MET activation in Head and Neck Cancer
- In light of the novelty of this product, at least half of the U.S. and German physicians insist that end points are key, with the MoA acting only as a support point
- XL184's MoA appears to be more interesting than the comparator's MoA because historically, the comparator's MoA has never lead to an efficacious treatment
  - XL184's novel MoA has not been disproven, therefore, it currently holds some interest

"This is a novel option and a different pathway." - Hem Onc, US

"Maybe it only works on those with MET amplification…" - Hem Onc, US

"This is a fairly promiscuous inhibitor. How many others does it hit? I think there is a role for MET." - Hem Onc, US

"Endpoints count… the MoA may or may not help support the superiority." - Onc, Germany

XL184

Efficacy is Well-Received, but Germany Has Concerns about Oral Administration

- Efficacy is seen as impressive with a three month increase in overall survival
- The safety profile is seen as acceptable by the majority of U.S. and German physicians, however, a minority was skeptical, expecting more toxicity
- Germany physicians are concerned about the oral form since patients might develop swallowing problems after radiation in the neck and neck
- U.S. interest in this product is stronger than in Germany
  - XL184 could be viewed as a 1st line agent in the U.S.,
  - It would be viewed as 2nd line in Germany

"Compared with the standard of care, this has good survival benefits. It seems to address a different target vs. Erbitux…. It is Avastin-like… it has contributed to the prolonging of survival." - Onc, Germany

"I am skeptical of the diarrhea. I get this much with Erbitux itself. What about mucositis and skin rash?" - Onc, US

"If they get radiation in neck and throat area, swallowing can be a problem… Oral may not be the best." - Onc, Germany

"Swallowing is the first screening criterion here. It has to be squamous - other than that, the inclusion seems quite generous." - Onc, Germany

Recommendation

Recommendation

- Further market research is needed in that the competitive landscapes are changing
  - Gastric Cancer: after the completion for the Research, Herceptin in combination with chemotherapy is approved by EU to treat HER2 positive metastatic stomach (gastric) cancer
  - HRPC: announcement of positive trial result of Cabazitaxel increased survival for patients with advanced hormone-refractory prostate cancer
- Communication of MET and RET to the medical community is needed if XL184 would like to be considered beyond VEGFR inhibitor only
- Further market research to understand MET and RET is conducted only after adequate communication is achieved

EXHIBIT N

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
DOCKET NO. 3:11-cv-05446 PGS-DEA

YUE YU, :
Plaintiff, :
-vs- :
HOLLY McGRATH & BRISTOL-MYERS :
SQUIBB, INC., :
Defendants. :
- - - - - - - - - - - - - - - - - - - -X

DEPOSITION OF: JILL OROSZ
MONDAY, DECEMBER 17, 2012

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TRANSCRIPT of a deposition taken by and before MADALENE PALAZZO, a Certified Court Reporter and Notary Public of the State of New Jersey, in the above-entitled matter, on Monday, December 17, 2012, held at the FEDERAL COURTHOUSE, 402 E. State Street, 6th Floor, Trenton, New Jersey, scheduled to commence at 10 o'clock in the morning.

you work with Holly on?

A. Several.

Q. Could you please state?

A. EVRI. XL184. I think. I'm not sure -- no. No. Just those two.

Q. What do you think of McGrath as co-worker?

A. I'm sorry. Repeat that.

Q. What do you think of McGrath as co-worker?

MS. WIWI: Objection. You can answer.

A. What did I think of her personally? Professionally?

MS. WIWI: As co-worker. The question was as a co-worker.

A. As a co-worker? I've worked with better.

Q. Pardon me?

A. I've worked with better.

Q. Can you say again? I didn't hear you.

A. I have worked with better.

Q. Okay. Could you describe better?

A. I'm more accustomed to a higher caliber of market research. And a more collaborative approach.

Q. Could you explain what means higher

caliber?

A. Based solely on the projects that I worked with her on I found it difficult to obtain the information required for the business.

Q. Do you keep in touch with McGrath after you stopped working with her?

A. One email and that's it.

Q. Do you know that McGrath no longer works for Bristol-Myers Squibb?

A. No.

Q. Did you work with Miss Yu, me, from September 2009 to March 2010?

A. I don't recall those dates. I recall the early part of 2010.

A. I was on maternity leave in September 2009 through December 2009.

Q. Okay. Do you recall when you first meet with Miss Yu?

A. Could you repeat the question?

Q. Do you recall when did you first meet with Miss Yu?

A. My recollection is at the pilot market research in Fort Lauderdale for XL184.

Q. Did Miss Yu conduct any market research project for your brand or your compound?

A. Given the context of our portfolio.

Q. So after XL184 was given back what other products you work on? Did you stay with the team or you move on to other positions?

A. I work on special projects.

Q. Within?

A. Global oncology until I was placed in this new role.

Q. There's document. This BMS0003. We will mark this statement.

MS. WIWI: Are you going to mark it for identification the exhibit? Or are you just identifying it?

MS. YU: Exhibit.

(Whereupon, Exhibit Orosz-1 is marked for identification.)

Q. So there's a part in the middle. There's your name there?

A. Mm-hum.

Q. Can you just review the document -- the statement there? When you done let me know, please.

A. Mm-hum.

Q. Tell me was the statement truly made by you?

A. It was a long time ago. So it's hard to

say for sure.

MS. WIWI: What was the question? Could you read that back?

(Whereupon, the requested portion is read back by the court reporter.)

Q. Was the statement truly made by you?

A. It's hard to say. This is a summary of a long discussion that was had on the phone. I may have said these things but there may have been context that is missing from this.

Q. Okay. Do you recall whom you had the conversation with?

A. Some lady who called.

Q. Okay.

A. And said this was supposed to be anonymous.

Q. Okay.

A. And that she was doing an investigation for the company. I don't know what her name was. What department she was from. It was a long time ago. I remember talking to her for quite some time.

This seems to summarize the discussion but I don't see some of the context from what I believed to be the case when I talked to her.

Q. So can you say which again? I'm sorry. Just I know it's long time ago. Can you just check your memory? I'm sorry. Recall the projects Miss Yu did for XL184. I think the title for that report -- for that project was XL184 frame of reference.

MS. WIWI: Objection.

A. Okay.

Q. And --

A. -- What question do you have for me?

Q. Just is any statement -- sentence there you want to make a correction that does not seem right to you?

A. The third sentence.

Q. Can you read it for me, please?

A. "Orosz stated Yu was at kickoff meeting and was not achieving objectives that were outlined in that meeting."

Q. Okay. That's not correct. Why is that?

A. The objectives for that pilot market research were discussed with Holly. There were no objectives outlined in that meeting from Florida.

It wasn't a kickoff meeting either. It was market research. Pilot market research in Florida. Sentence three does not summarize what I had shared.

Q. Number three which is you, right? You stated. Okay. Anything else from the statement not cooperate with your memory?

A. Well, the whole third statement didn't make sense. It's not like it's right or wrong. It doesn't even make sense in terms of context of the discussion and what is happening.

Q. The whole statement?

A. So I can't just sit here and say his word doesn't make sense. This part doesn't make sense or is inaccurate.

The whole third sentence doesn't make sense. There was no kickoff meeting.

Q. Okay. How about next sentence?

A. I didn't use words like use documentation. That's not the type of language I use. So it's inaccurate because I wouldn't have used documentation. And was low compared to the objectives. Again, doesn't make sense because the objectives were set with Holly and they changed in Florida.

Q. The meeting in Florida was in January?

A. This time report she's referring to is in March. A lot of that had taken place and the objectives had changed quite a bit. So there's a

EXHIBIT O

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
CIVIL ACTION NO.
3:11-cv-05446-PGS-DEA

YUE YU,
Plaintiff,
vs.
HOLLY McGRATH and BRISTOL-MYERS SQUIBB,
Defendants.
- -X

Wednesday October 24, 2012

Oral sworn deposition of SUSAN HEINBERG, 9 Benjamin Rush Lane, Princeton, New Jersey, 08540, taken at the Clarkson S. Fisher Building and U.S. Courthouse, 402 East State Street, Trenton, New Jersey, before Patricia R. Frank, Certified Court Reporter and Notary Public of the State of New Jersey, commencing at 12:24 p.m., on the above date, there being present:

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A P P E A R A N C E S:

YUE YU, ESQUIRE,
105 Park Place
Kearney, New Jersey 07032
Plaintiff Pro Se

LOWENSTEIN SANDLER PC,
BY: AMY KOMOROSKI WIWI, ESQUIRE,
65 Livingston Avenue
Roseland, New Jersey 07068
(973)597-2336
Attorneys for Defendants

ALSO PRESENT:

IVELISSE CLAUSELL, ESQUIRE,
Bristol-Myers Squibb
Senior Counsel
HR Law/Global Privacy
P.O. Box 4000
Princeton, New Jersey 08543
(609)252-5615

BY MS. YU:

Q Firstly, is this a true statement you provided to Ms. McElarney when she contact you?

MS. WIWI: Objection.

THE WITNESS: Ms. McElarney contacted me if that's -- I didn't recall her name but I see it here -- in the spring of 2010 and interviewed me.

BY MS. YU:

Q Does this statement reflect what's your statement to Ms. McElarney?

A To the best of my recollection it does.

Q In your statement here one, two, three, four, five --

A I would like to clarify, this was not my statement. This is a summary that was prepared by Ms. McElarney.

Q Okay. If there's any errors or not truly reflect what's your reflection, you can tell me now. You know, if she mistaken something you meant to be recorded here, you can tell me.

A What I'm saying is this is not my statement. This is a report that was prepared by Ms. McElarney.

Q Yes. We understand that.

A Okay.

your thinking that you wanted to be on the e-mail list?

MS. WIWI: Objection. I'm not sure that was a question.

MS. YU: Please let the record reflect Ms. Heinberg didn't request her to be copied on the e-mails with vendors.

MS. WIWI: Objection.

BY MS. YU:

Q You state here that Ms. Yu was corresponding directly to the vendor. She was not aware of the wrong, slash, lack of the information Yu was requesting from the vendor, which delayed the projects?

MS. WIWI: Objection.

Q I'm asking a question here. The statement, can you give me more details on your statement here?

A What kind of details are you asking about?

Q She was requesting -- you know, you read the two sentence -- the last sentence of the first paragraph.

A I see the sentence. I just don't understand what details you're looking for in your

question.

Q Well, what's the cause of the delay of the projects? You state here caused delays in the projects. What was the cause?

A Well, what I see in the statement is that there was correspondence going on between Ms. Yu and the vendors. There were requests to the vendors as part of these e-mails. I did not see these requests. And there was either the questions that didn't correspond to the questions that our team actually had or maybe incomplete questions that didn't ask for all the information that we needed. And that meant that when the projects weren't -- weren't -- you know, wasn't corresponding to the questions that we had.

Q Okay. We'll come back to this project later when I review all the documents here.

MS. WIWI: I'm sorry. What documents are you talking about?

MS. YU: What documents? Just all the bunch of e-mails and all the e-mails because here it's not clear. Ms. Heinberg doesn't have enough information with details to support the statement here, yes, and also I -- you know, if your e-mail had my correspondence with the vendors, several

A Yes.
Q Can you identify the two -- the projects you referred here?
MS. WIWI: Objection. Refer to where? What are you talking about?
MS. YU: Here, the first sentence, Heinberg stated Yu was also assigned to manage the budget for the two projects. So I asked Ms. Heinberg what are the two projects.
THE WITNESS: I don't -- I don't recall what two projects were being referred to here. It could be that it was for Ixempra and for the breast tumor strategy group.
BY MS. YU:
Q And also for the next, Heinberg indicated Yu had difficulty managing the budgets, stating there was a large amount of money left in the budget in late 2009 which should have been used for the project. So how much money left in the budget?
A I do not recall.
Q If as you said the large amount of money not used, you can't remember how much money wasted?
A I don't recall how much was left.
Q Which should have been used for the project. Which project did you refer to?

A I believe in that case I was referring to the hormone-resistant breast cancer question project.

Q Hormone resistant? That project you mentioned about the hormone-resistant data request?

MS. WIWI: Objection.

Q Is that the one you referred earlier?

A The project with regard to answering questions for hormone-resistant breast cancer.

Q Let me just write down. The next sentence here, Heinberg also indicated there was many times she and Yu were scheduled to meet but Yu was out of the office or canceled meetings which caused delays in completing the projects. First of all, how many meetings were canceled for Yu was out of the office?

MS. WIWI: Objection.

THE WITNESS: I do not recall the exact number.

BY MS. YU:

Q No? Caused delay in completing the projects is plural. How many projects were caused delay?

MS. WIWI: Objection.

THE WITNESS: I believe in this

Q Heinberg informed McGrath that she had communication issues with Yu as well as Yu's lack of delivering projects on time. Can you provide some details? When did you inform McGrath you had communication issues with Ms. Yu?

MS. WIWI: Objection.

THE WITNESS: I don't recall when I talked to Ms. McGrath. I know it was sometime in March, and I called Ms. McGrath because I was concerned about the fact that this project with regard to hormone-resistant breast cancer hadn't completed yet. I felt a lot of pressure to make sure that we met the deadline, and in my recollection I hadn't been -- I was not feeling reassured that Ms. Yu was going to be able to deliver the project in time.

BY MS. YU:

Q That was in March 2010?

A Yes.

Q Did you have concerns or complaints to McGrath before March 2010?

A No. I had concerns. I did not make a complaint to Ms. McGrath before March.

Q Would you be surprised to hear McGrath informed me on January 20, 2010, to end my

to set up the data, the data requests, and then they did the data requests and they analyzed the data. And, as I recall, in the summer of 2010 the work was completed to our satisfaction with those two vendors.

Q Did you ever request -- did you ever provide a deadline to Ms. Yu with regard to getting the data?

A I remember being concerned about the fact that that timeline kept shifting and, as I recall, I was sending e-mails, especially when a couple of meetings got canceled, saying we really need to see this data, you know, mentioning that we had a presentation coming up and that we needed -- it was very important to meet with the vendor and see what they had done.

Q Did you ever set a deadline?

A I believe -- I believe I mentioned that there was some time by which I wanted to make sure we had met with the vendor. I don't know if I set an exact date, that we needed it by this date.

Q And did you ever contact Holly McGrath to express your concern with regard to the progress of this project?

A At some point in March I recall I called